Minutes
DPHHS Rates Commission
September 27, 2006
Capitol Room 152
Helena, Montana

Attendees: Diana Tavary – Vice Chair, Wayne Hershey, Mary Jean Golden, Frieda Houser, Barb Varnum, Representative Christine Kaufmann – Chair, Senator John Cobb, Lois Steinbeck, Bob Anderson, Janet Whitmoyer, James Corrigan, Jani McCall, Jim Fitzgerald, Gail Briese-Zimmer

Absent: Representative Penny Morgan, Senator Dan Weinberg, Kathy Brophy, Bob Olsen.

Guest: Kevin Quinn – ACS, Terry Krantz – ACS, Marilyn Daumiller – LFD, Charlie Briggs – MACDS, Jan Cahill – Quality Life Concepts, Jeff Sturm – DDP, Kelly McNurlin – DSD, Jeff Harrison – OPCA, Mary Runkel – PHSD

Welcome & Introductions
Representative Christine Kauffmann – Chair:
Commission and guest were welcomed to the meeting.

Approval of Minutes
Commission Members:
Motion to approve the minutes was made and seconded. Minutes were approved with no opposition.

Framework for Setting Health Care Payment Rates
Kevin Quinn – ACS Government Healthcare Solutions:
Value Purchasing:
Kevin stated that the department spends approximately 700-750 million a year on Medicaid. It is approaching 20% of the state budget. Nationwide Medicaid became the number one item in state budgets about a year ago. He went over the provider groupings by FY06 Medicaid reimbursement. He went over the change from Medicare and how Medicaid started in 1965. Payment methods are probably the biggest lever a Medicaid plan has to influence how healthcare is delivered and how much it costs. Incentives make a difference in payment methods. He went over what value purchasing would be in a more perfect world.

Kevin gave ten suggestions for value purchasing. The first three are general, next two are payment levels and the last five are payment methods. He stated that there are a few things that Montana does well that other states could learn from. He stated that there are several different provider types where Medicaid is the primary payer. Kevin went over what the Medicaid market is in Acute care and Long-Term care.

There are two roles of Medicaid:

	Medicaid *in* the Market	Medicaid *is* the Market
Markets	Hospitals, physicians, dental, drugs	Personal care, ICF/MRs, adult day services
Key Submarkets	Cancer, cardiovascular, dialysis, orthopedics	Obstetrics, neonatology, pediatrics, mental health
	Medicaid beneficiary needs often similar to those of general population	Medicaid beneficiaries often special populations
	Medicare, private plans have most influence	Medicare, private plans not as important
	Other payers play significant role in covering cost	Providers may depend on Medicaid to cover costs

Payment Levels:
Kevin gave a framework for applying evidence based for Medicaid purchasing. If access to quality care its not acceptable then Medicaid can fix it by looking at where the best return on investment is. He went over the federal rules that are important to Medicaid. He stated that there are a few statutory floors and ceilings on Medicaid rates. Using evidence is easier than ever with today's technologies. He showed some examples of types of information that is available to the public.

Kevin gave some suggestions for interpreting evidence.

- Focus first on access and quality
- Work with providers to rely on evidence rather than anecdote
- Trends in access are often more helpful than absolute numbers
- Provider charges can be unreliable benchmark
- Medicaid role in the market varies widely by provider type
- Money isn't always the answer

Kevin went over a graph that shows what the percentage of Medicaid fees compared to Medicare fees. Overall Montana Medicaid fees are approximately 96% of Medicare fees. There are a couple of states that are only one-third of Medicare and some where Medicaid pays more than Medicare. He gave a comparison of average nursing facility rates per day over several states surrounding and including Montana and the US overall.

He showed a chart that compared the percentage of concerns from physicians about Medicaid in 2002. The highest percentage was reimbursement at 38% followed by billing paperwork at 28%. .

Kevin gave four options for finding the best ROI:

1. "Matchmaking" clients and providers

a. Kevin showed a webpage that Mississippi uses for Medicaid clients that will allow them to look up providers that will take Medicaid

2. General rate increase
3. Focused rate changes
4. Reducing provider cost and frustration due to…
    - Coordination of benefits
    - Cost-sharing can't be calculated at point of service
    - Prior authorization hassles
    - Avoidable denials
    - Unclear manuals
    - Retroactive payment changes
    - Hard to get answers
    - Paper processes

Payment Methods:
Kevin stated that in the package he handed out is some information on some payment methods. In regards to payment methods there are four themes for coming years: consolidation and dissemination of Medicare methods, continual struggle over risk between payer and provider, experiment with payment for quality, and an uneven pace of change. With payment methods they are trying to "pay more to those who do more." In 1965 providers were paid a percentage of their cost or their charges. Fee for service philosophy is paid by the service. The DRG revolution in 1983 was when Medicare introduced payment by stay case mix adjusted. The next revolution will give better quality and better outcomes.

There are eight basic payment methods: per time period, per eligible person, per recipient, per episode, per day, per services, per dollar of cost, and per dollar of charges. He gave an outline of what way states purchase inpatient care. He went over unit of payment in Montana Medicaid and the best practice for balancing vs. efficiency. He gave a brief overview of payment methods and quality history.

Public Comment
It was asked how often should a system be looked at and what is needed to make sure that methods and levels are up to date. Kevin stated that the systems should be looked at annually. In terms of methods and levels he stated they should be looked at every three or four years.

It was asked what rule of thumb is for the cost of a rebase. He stated that it really depends on the complexity of the rebase.

It was asked how the department defines quality. Kevin stated that these can be determined by looking at what Medicare studies have show as quality care facilities. Some analysis can be done from the department's data.

It was asked how the state would respond to the challenge of having to unbundled services. Kevin stated that the best thing would be to get together the interested parties

and ask what the questions are and ask if there is evidence that will help address those questions. After finding the evidence come back and look over what is to do next.

It was stated that as a provider the presentation was easy to follow but it was frustrating that it was not easy to figure out groups like dd. It was asked if it was possible to make that easier to understand. Kevin stated that it is possible. It is a good idea to ask what the state is trying to pay for.

Update on DDP Rates

Jeff Sturm – DDP:

Jeff went over the handouts that show what the children's rates are, the science of how they came up with them, and the update on adult service rates. Adult rates were piloted in region two, great falls area. They moved on the implementation plan into regions one and three with adult rates. There is a resource allocation that goes on between different provider agencies. Because of the issue of having to do it in regions one and three and not having enough resources in those regions they had to put a five percent stop loss on them until region four and five are in. In July 1 of 2007 it will be put into a standardized rate for those two regions. Personal Support Planning system is also being implemented into regions one and three. There are two rates that are new and those are adult foster care and assisted living.

Jeff stated that the major child service is Family Support Specialists (FSS) services. The other activities that families buy from child and family services are the same as adult. The major focus on children's was how to pay for FSS. There were two time studies done with FSS and two factors that need to be looked at: how much time does a family get and an FSS has bundled activities that CMS wants unbundled. The average family gets 13.2 hours of FSS services and training and case management activities for those hours are about 50/50. When they came up with the rate they looked the two activities of an FSS as case manager: what a benchmark is for case managers and what a benchmark is for a trainer (teacher) and that is where they came up with the rate of 15.14 an hour. That rate was then blended and then they used all the other components to come up with the final rate of 36.67 and multiplied that times 13.2 for a monthly rate of 483.22. Beginning October 1st with children's services they are saying that for every child that is in the IFENS Program will get 467 a month for the FSS and then for every other service they will bill at the other rate.

Jeff stated that respite rate can get complicated because some agencies pay their employees directly or they can have the families pay them with no corporation respite. There are a couple tools that have been designed: the mona and mini-mona. They are designed to identify how much a child should cost per service. They have done a mini-mona or a mona on everyone with services and then the family takes it and begins to develop a cost plan. They have stated that every family must purchase the FSS services but the remaining dollar amount that child was established at they have to spend on other services in the individual cost plan. There is an upper cap in respite. Approximately 300 children will be piloted in this. It will be run and then if successful it will be

implemented into regions three, four, and five. They will be able to rebase every two years.

Jan Cahill – Quality Life Concepts:
Jan stated that Jeff covered most of it. He said that right now it is hard to decipher if the rate is going to work sufficiently at this moment.

Public Comment
It was asked how providers are feeling about the process. Charlie Briggs from MACDS stated that there was really only one agency that came out lower than they had planned. That agency has other payer that made them able to compensate for the loss. On balance region two providers were generally satisfied. However, in regions one and three there are providers that are struggling.

It was asked with the rebasing how much is cost anticipated. The division has indicated that they want to start the process a lot earlier. Providers have stated that this is the first time in 35 years that they have been asked what their actual cost is.

It was asked if DDP has a goal like HRD has to help make the family self sufficient. Jeff stated that there is no goal because of the types of families in the program. The children needing these services are more likely going to need them for the duration of their life.

It was asked if the family can keep the money not spent on respite for the next year. Jeff stated that the money cannot be carried over. General fund can be put away for future services.

Finalize By-Laws
Commission Members:
It was decided that due to time constraints the by-laws would be voted upon via e-mail.

DPHHS Ten Year Rate Increase History
Jeff Harrison – OPCA:
Jeff went over what the document covers and gave a brief overview. It was suggested that comments and questions be sent to Gail Briese-Zimmer to be forwarded to Jeff Harrison. The comments will be looked at and changes made so that the document can be ready for the November meeting.

Wrap up & Adjourn
Meeting adjourned at approximately 4:15. Next and final meeting of the year is set for November 15, 2006 at 2401 Colonial Building in the 3rd floor Board of Investments conference room.